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### Credibility and impact: Two sides of the same coin (Editorial)

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## **Editorial: Credibility and impact: two sides of the same coin**

The clinical role of the nurse educator has been much debated over the past two decades in the UK. However, it does not appear to be such a contentious topic in other countries, an interesting observation in its own right. It is, perhaps, no accident that escalation of the debate in the UK coincided with the move of nurse training into higher education and with the increasing emphasis on nursing as an academic (and thus research active) discipline. The historical context of this movement has been covered extensively in the nursing literature and it is not our intention to rehearse that context further. Suffice to say, for many, the move has been associated with some uncertainty and confusion regarding nurse lecturers' role within the changed context of nurse education. There is concern that:

- Nurse education has become increasingly distanced from practice (Maslin-Prothero & Owen 2001, Rattray 2004);
- There are expectations amongst practitioners, students, and nurse educators themselves regarding the importance of being clinically credible (Fisher 2005);
- Without regular exposure to practice, nurse lecturers will be unable to maintain their clinical credibility (Barrett 2007);
- Nurse educators must demonstrate clinical credibility to address the theory-practice gap and that it is this that preserves their right to continue teaching nurses (Meskell *et al.* 2009);
- Because lecturers are often seen as lacking clinical credibility, this leaves them feeling vulnerable in practice. It renders them a 'soft target' for criticism (Rattray 2004).

Ousey and Gallagher (2010) called for the discussion on this issue to cease because it creates an unnecessary distraction. We entirely agree: after all, we are 15 years on from the UK integration with higher education and it is with some hesitation that we add a further small ingredient into the pot. However, our discussion may move the debate towards the closure for which Ousey and Gallagher call. To achieve this we discuss the issue of 'clinical impact'. Specifically we argue that this is not only a legitimate, but a *crucial* component of credibility.

We have already sketched an outline of some of the current tensions regarding credibility. It may be helpful at this point to explore some of the underpinning reasons for such tensions. There are several sticking points, namely: lack of clarity about the meaning of credibility and how it is to be achieved. The term 'credibility' is berated by those who try to define it and it has been described variously as 'ill-defined', 'ambiguous' and 'nebulous'. Part of the problem is that it is often used interchangeably with competence, but these are in fact, very different concepts. Fisher (2005) reported that clinical credibility is associated with: clinical currency, hands on care, being visible in clinical practice, transferability of skills and role development. On the other hand, Rattray (2004) suggested that credibility is more about knowledge and awareness of current practice, than being competent in 'hands-on' nursing. Similarly, Brennan and Hutt (2001) make a distinction between clinical 'competence' as the ability to deliver direct patient care and clinical 'credibility' as implying scholarship in the field.

In addition to the conceptual confusions regarding clinical credibility, there is also some concern about how to interpret related nursing policy. In the UK, it is a requirement of the Nursing and Midwifery Council (NMC) (2008) that in addition to teaching and research, nurse lecturers are required to spend at least 20% of their time in clinical practice. Some nurse academics have interpreted this as a need for them to have a physical presence in a clinical setting. Again, this has created some aerated conversations. Brennan and Hutt (2001) highlight the difficulties for nurse lecturers in juggling demands of teaching, research, administration, course development and spending time facilitating practice based teaching. Similarly, Barrett (2007) argues that strong knowledge of the subject area is a prerequisite for effective teaching, but lecturers maintain this through reading, writing and research – as opposed to spending time directly engaging in clinical care. Barrett argues that relinquishing clinical obligations leaves additional time for increased publication and research output, thus raising the profile of the university concerned and nursing in general.

Although some scholars highlight the problems of nurse teachers engaging with directly with clinical practice, this does not mean that they completely eschew the notion of maintaining links with clinical practice. Indeed there is agreement that developing strong partnerships between academia and practice is necessary (Meskell *et al.* 2009, Ousey & Gallagher 2010). Overall, it is likely to be a matter of what we mean by *in* clinical practice. It is important to remember that the requirement for teachers to support practice-based learning may be achieved through a variety of strategies such as:

- Acting as a clinical teacher or a link tutor;

- Preparing, supporting and updating mentors and practice teachers;
- Taking part in practice-based action learning groups;
- Contributing to practice development;
- Undertaking practice-based research activity.

It is our contention that nursing may be placing too much emphasis on the first of these strategies, thus interpreting the NMC requirement as necessitating direct links with practice. Being *in* clinical practice however, does not necessarily require a physical presence. It encompasses a range of practice-related activities through which nurse academics can contribute to (and be associated with) practice. Specifically, refocusing on the final point may be helpful. Contribution to evidence-based nursing practice (NMC 2008) should carry as much weight as linking directly with clinical practice. It may be that nursing has become so hamstrung on the notion of achieving the first, that it has lost sight of the latter. We ought to be concerned equally about the research we undertake, especially with its credibility in, and application to, practice. Perhaps one way of doing this is to consider its impact.

The issue of impact is one that has gained momentum over the past year across all Higher Education institutes in the UK. As we begin to construct pilot impact statements for the Research Excellence Framework (REF) expected in 2013 a pressing issue is that: ‘significant additional recognition will be given where high quality research has contributed to the economy, society, public policy, culture, the environment, international development or quality of life’ (Higher Education Funding Council for England 2010). With this in mind, nurse academics are charged with scrutinising the impact of their

research on practice. For researchers therefore, the notion of contributing to a government policy review or national clinical guidance development becomes much more clinically credible and practice relevant than turning up once a month to observe a wound dressing.

Last year was the 50<sup>th</sup> anniversary of the Royal College of Nursing (RCN) Research Society. As part of its celebrations a number of exercises were undertaken to elicit the most influential nurse researchers from the past few decades (Topping 2009). Felicity Stockwell, Patricia Benner and Jack Hayward were all acknowledged as significant contributors to nursing care – the details of which do not need to be spelled out here. Three other people emerged as having had consistent influence in nursing research over a period of years: Karen Luker, Nicky Cullum and Anne-Marie Rafferty. The work of these individuals (and that of many others of course) has had a significant impact upon the way we deliver and organise nursing care. They serve as a reminder regarding the direction for nursing research – that is, the importance of getting evidence into policy and delivering research with impact (Topping 2009).

Impact is surely the best marker of clinical credibility that there is – it is something we should be celebrating and emphasising. Look to the future of nursing, longitudinal clinical credibility will be measured by impact on the profession, not by how many hours a month lecturers can spend in a clinical department. Credibility and impact are quite simply two sides of the same coin.

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